U.S. Naval Hospital Naples

Continence clinic Questionnaire

The following questions make up a screening questionnaire that will help us in caring for you. Your answers may indicate whether certain tests would be appropriate in helping to evaluate the health. If you have any questions, please ask your health care provider.

Name_____ SSN (of sponsor if dependent)_____FMP____

Rank/Rate(active duty)_____ Duty Station_____Phone# (H)_____ (W)_____

Age_____ HT_____ WT_____Race_____ Religious Preference_____

Primary Language _____Single___Married___Divorced___Widowed___

Husband/Partner _____ Rank/Rate (if AD)_____ Race_____

Duty Station _____ Phone # _____

Address_____

E-mail_____

UROGYNECOLOGICAL HISTORY **How long has you had any of these problems ____mos ____yrs**

Do you have any of the following problems:	YES	NO
1. Blood in the urine	____	____
2. History of being a bed wetter as a child	____	____
At what age did you stop? _____		
3. Recurrent urinary tract infections	____	____
4. Psychiatric problems or medications?	____	____
Please specify _____		
_____		
5. Diabetes	____	____
6. History of blood transfusion	____	____
7. Pelvic radiation	____	____
If yes, for what condition? _____		
8. History of kidney infections	____	____
9. Any previous bladder surgery?	____	____
If yes, what type? _____		

10. Hours between voids _____
11. Voids per day _____
12. Voids per night ____
13. Leakage of urine ____ ____
    If yes, number of leaks per day____
    Amount of leak:
        Few drops ____
        Wetting a pad ____
        Fully soaking underwear w/wo pad ____

PATIENT IDENTIFICATION

UROGYNECOLOGICAL HISTORY CONTINUED **YES** **NO**

14. Loss of urine with cough, laugh, sneeze, standing, exercising? ____ ____
    please circle which mode causes leak
    If yes, does it require the following:
    Mild activity/sneeze/cough ___
    Moderate activity ____
    Heavy activity/strong cough/sneeze ____
15. Loss of urine associated with urge to go before leak ____ ____
16. Do you have "triggers" that cause urgency/incontinence such as water running, hearing water pouring, etc. ____ ____
17. Do you wake up with a wet bed? ____ ____
    If yes, how many times per night ____ or week ___
18. Do you have to use a pad ____ ____
    If yes, how many times per day? ____
    Per night? ____
    Type of pad: mini___ regular ____ heavy ____ adult diaper ____
19. Have you tried Kegels for this problem ____ ____
    Did it work? ____ ____
20. Have you been prescribed medications for incontinence? ____ ____
    If yes, what type _____
    Did it work? ____ ____
21. Are you aware when your bladder is full? ____ ____
22. Are you aware when you're wet? ____ ____
23. Do you have pain with urination? ____ ____
24. Do you have pain with filling of the bladder? ____ ____
    If yes, does the pain go away with urination? ____ ____
25. Do you have pelvic pressure? ____ ____
26. Do you sense a bulge in the vagina? ____ ____
27. Have you ever used a pessary for this problem? ____ ____
    If yes, what type? _____
28. Do you have to splint (place fingers in the vagina) to urinate? ____ ____
29. Do you have to splint to have a bowel movement/stool? ____ ____

Voiding habits	**None/Never**	**Sometimes**	**Often**	**Always**
Urgency *urge to go*	_____	_____	____	____
Hesitancy *hard to start*	_____	_____	____	____
Straining	_____	_____	____	____
Intermittancy *flows interrupts*	_____	_____	____	____
Incomplete emptying	_____	_____	____	____
Dribbling	_____	_____	____	____

PATIENT IDENTIFICATION _____

OBSTETRIC HISTORY

Number of past pregnancies _____

1. Number of miscarriages and/or abortions_____

2. Number of children now living _____ Term _____ Preterm _____
   If yes, answer date, weight and method of delivery. Largest baby weight _____
   _____
   _____
   _____
   _____

3. Have you ever received Rhogam?_____

GYNECOLOGICAL & MENSTRUAL HISTORY	**YES**	**NO**
1. Are you sexually active?	____	____
If yes, vaginal ____ Other _____		
2. Altered due to prolapse?	____	____
3. Pain with intercourse?	____	____
If yes, what location: Entrance to vagina____ Deep ____ Both _____		
4. Intercourse satisfactory?	____	____
5. Able to achieve orgasm?	____	____
6. Leakage of urine during intercourse?	____	____
If yes, cause of leakage Penetration _____ Orgasm ____ Both ____		

7. Age at first menstrual period _____

8. How often are your periods? Every _____ days, lasting _____ days.

9. Do you usually have severe cramping with your periods? _____

10. What was the first day of your last NORMAL period? _____

5. Have you had the following:

a. unusual breast lumps or discharge from the nipples	_____	_____
b. repeated vaginal infections, pelvic inflammatory disease	_____	_____
c. abnormal pap smears	_____	_____
d. sexually transmitted diseases	_____	_____
e. infections of the uterus, tubes or ovaries	_____	_____
f. a diagnosis of pelvic inflammatory disease	_____	_____
g. surgery of your tubes, ovaries, uterus or vagina	_____	_____
h. any symptoms of hot flushes, difficulty sleeping, mood swings	_____	_____

MEDICAL HISTORY	**YES**	**NO**
1. Have you ever been hospitalized	_____	_____
If so, for what diagnosis		
_____		
2. Do you have any chronic health problems?	_____	____
3. Do you routinely have headaches, (prior to pregnancy)?	_____	____
4. Do you have, or have you ever had, seizures or convulsions?	_____	____

PATIENT IDENTIFICATION

MEDICAL HISTORY CONTINUED **YES** **NO**

5. Do you have any problems with your vision or eyes? _____ _____
(not including wearing contacts or glasses)

6. Have you ever had problems with your thyroid gland? _____ _____
What?_____

7. Have you ever had problems with your lungs? _____ _____
(i.e. pneumonia, asthma, bronchitis, tuberculosis)

8. Have you ever had problems with your heart? _____ _____
(i.e. heart murmur, rheumatic heart disease, heart surgery,
"heart attack", high blood pressure)

9. Do you have problems with your stomach or intestines, _____ _____
i.e. constipation, diarrhea, hemorrhoids (before pregnancy)?

10. Have you ever had a blood transfusion? _____ _____
When? _____

11. Have you been told by a health care provider that you are anemic? _____ _____
When? _____

12. Are you seeing a health care provider
for problems with your muscles or bones? _____ _____

13. Have you had any mental or psychiatric problems that required counseling? _____ _____

14. Do you have any other health problems that we should know about? _____ _____
Explain:_____
_____
_____

15. Have you had or been immunized for:
a. Rubella (German measles or 3 day measles) _____ _____
b. Rubeola (two week, hard, or red measles) _____ _____
c. Varicella (Chicken Pox) _____ _____
d. Hepatitis B _____ _____
e. Hepatits A _____ _____
16 Have you ever had a positive PPD? _____ _____
Were you treated? _____

MEDICATIONS **YES** **NO**

1. Do you take any medications routinely? _____ _____
What and how often? _____
_____
_____

PATIENT IDENTIFICATION

ALLERGIES **YES** **NO**

1. Do you have allergies to any medications? _____ _____

If yes, which medication and what type of reaction?_____ _____ _____

_____

2. Do you have allergies to any foods?_____ _____ _____

3. Do you have a latex allergy? _____ _____

SURGICAL HISTORY **YES** **NO**

1. Have you ever had any operations or surgeries? _____ _____

What and when? _____

_____

_____

SOCIAL HISTORY **YES** **NO**

1. Do you smoke? _____ _____

How many packs/day? _____ How many years? _____

2. Do you drink alcoholic beverages? _____ _____

How many drinks/week?_____

3. Do you/have you used illicit or illegal drugs _____ _____

if so, what _____

4. Are you currently employed _____ _____

if so, what _____

What type of job? _____

5. Do you have heat in your home? _____ _____

6. Do you have a phone in your home? _____ _____

7. Have you ever been the victim of sexual, physical or emotional abuse? _____ _____

EDUCATIONAL HISTORY _____ _____

1. How many years of school have you completed? _____
2. How many years of school has your partner completed? _____
3. Do you plan on taking childbirth preparation classes? _____

FAMILY HISTORY

1. Do you or the father of the baby have any close family members with:

	Yes	No		Yes	No
diabetes	_____	_____	cancer	_____	_____
tuberculosis	_____	_____	high blood pressure	_____	_____
heart attack	_____	_____	heart problems	_____	_____
twins	_____	_____	bleeding problems	_____	_____
cystic fibrosis	_____	_____	Down's syndrome	_____	_____
hemophilia	_____	_____	mental retardation	_____	_____
spina bifida	_____	_____	muscular dystrophy	_____	_____
anencephaly	_____	_____	hydrocephalus	_____	_____
incontinence	_____	_____	prolapse of vagina/pelvic organs	_____	_____

PATIENT IDENTIFICATION_____